



Patient Acknowledgment of Receipt of Notice of Privacy Practices

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Patient First Name:	
Patient Last Name:	
DOB:	
I,	
, hereby acknowledge that I have reviewed and received a copy of this office's Notice of Privacy Practices explaining:	
	<input type="checkbox"/> How this office will use and disclose my protected health information. <input type="checkbox"/> My privacy rights with regard to my protected health information. <input type="checkbox"/> This office's obligations concerning the use and disclosure of my protected health information.
I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices upon request.	
I also understand that if I have any questions or complaints, I may contact: Tami (Practice Manager) at Windsor Family Dental (608) 846-5407 or tami@winfamdental.com	
You may also contact the Secretary of the U.S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Please contact our office for information on how to contact the U.S. Department of Health and Human Services.	

Patient or Personal Representative

Signature:	
Name:	
Relationship to Patient:	

For Office Use Only

We made a good-faith effort to obtain an acknowledgment of	
receipt of our Notice of Privacy Practices. In spite of these efforts, our office has been unable to obtain a signed acknowledgment of receipt for the following reasons (check all that apply):	
	<input type="checkbox"/> Patient refused to sign (date of refusal)
	<input type="checkbox"/> Communications barriers prohibited obtaining an acknowledgment. <input type="checkbox"/> An emergency situation prevented us from obtaining an acknowledgment.

	<input type="checkbox"/> Other
Attempt was made by:	
Date:	